**The DSHS Division of Alcohol and Substance Abuse has many partners in helping people prevent and treat addictions.**


- Funding for county, tribal and school-based services
- Contract Oversight
- Quality Assurance
- Workforce Capacity/Diversity
- Research and Evaluation
- Planning/Policy Leadership
- Program Certification
- Statewide Public Education
- Statewide Prevention

- Love
- Support
- Monitoring
- Positive Role Model

- Drug Education
- Intervention
- Referrals

- Mental Health Services
- FAS Prevention and Screening
- Job Training
- Medical Assistance
- Abuse and Neglect Prevention
- Funding Assistance
- Contract Oversight
- Research

- Evaluation and Research
- Cross Systems Collaboration
- Statewide Prevention Services
- Statewide Public Education
- Workforce Training
- Program Licensing
- Corrections-based Services
- Statutory Direction
- Budget Appropriation
- Oversight

- Referrals
- Treatment
- Housing Assistance
- Transportation
- Therapeutic Child Care
- Prevention
- Drug Education
- Parenting Education
- Employment Services
- Monitoring
- Case Management
- Drug Courts/Legal Services
- Advocacy

- SSI
- Substance Abuse Prevention and Treatment Block Grant
- Medicaid
- TANF
- Education Assistance
- Community Assistance

# Overcoming addiction:

## The Division of Alcohol and Substance Abuse

Drug and alcohol abuse are among the most costly problems in our society - costly both in public spending and in human suffering. *The News Tribune* in Tacoma recently reported, for instance, that a single male addict cost taxpayers $2.1 million over 11 years for court costs, jail time, emergency room visits, hospital care, ambulances, and related expenses. The amount of suffering caused by drug and alcohol abuse is suggested by a troubling statistic: in 38 percent of recent Child Protective Services referrals, substance abuse among parents and caretakers is identified as an issue, and social workers believe the true prevalence is probably even higher.

Drug and alcohol addiction is a major contributor to poverty, crime, family disintegration, and to government spending at the local, state and federal levels. A 1996 study estimated the total economic cost of abuse and addiction in Washington state at $2.54 billion.

The prevalence of drug and alcohol addiction is truly startling. Reliable studies indicate that as many as one in ten adults is drug or alcohol dependent. For many of us, this figure may seem difficult to believe, but addiction experts recommend a simple, personal test of its veracity: think through your own family tree, and you are likely to recall the drunk uncle, the drug-abusing cousin, or the recovering Alcoholics Anonymous member who contributes to this statistic. Chemical dependency is an illness that touches virtually every American family.

Chemical dependency is a brain disease in which the neurochemistry and receptor sites of the brain change, causing the need for drugs or alcohol to become as biologically driven as the need to eat or breathe. Scientists suspect that genetics play a role in making certain people more susceptible to this disease, but it's impossible to predict who will develop a dependency.

In spite of dramatic new knowledge about the physiology of chemical dependency, there is a great deal about addiction that remains a mystery. Because we do not fully understand the disease of chemical dependency, we do not yet have a sure-fire cure. This is true for many diseases - diabetes, for example, or depression, or even heart disease. But for all these diseases, we do have treatments that work - treatments that help people live with and manage chronic illnesses while leading generally healthy, productive lives.

What is unique about chemical dependency is that effective treatments have been developed by people who suffered from this disease - not by researchers or medical doctors. Organizations like Alcoholics Anonymous and other self-help groups pioneered the concepts of treatment that eventually led to the development of a professional discipline and a field of practice.

**Residents Receiving DSHS Services: SFY 2000**

| DSHS Services by Program | Total Clients |
|---|---|
| **Division of Alcohol & Substance Abuse** | **57,220** |
| Detoxification | 7,395 |
| ADATSA* Assessment | 12,525 |
| Residential Treatment | 9,885 |
| Outpatient Treatment | 47,535 |
| Opiate Substitution Treatment | 2,690 |
| Miscellaneous | 5,795 |

**ADATSA = Alcoholism and Drug Addiction Treatment and Support Act*

Source: The DSHS Client Data Base, Research and Data Analysis FY 2000

## HOPE for COAP

Healthiness Offers Peaceful Enjoyment for Children of Addicted Parents

***Services:*** Substance Abuse Prevention, Child Care Services

***Communities served:*** Children of Addicted Parents in Spokane County

***DSHS clients:*** 250 per year

***Private as well as public clients?*** No

***Year formed:*** 1995

***Employees:*** 6 paid, 2 work study, all part time

***Payroll per year:*** $23,324

***Total annual budget:*** $90,000

***DSHS or federal funding brought into the community through contract with DSHS:*** $33,450

In most cases, chemical dependency treatment consists not of medications or medical procedures, but of a curriculum - a course of study and reflection that helps people understand their life-long disease and gives them the tools to manage it. Some people go to inpatient treatment centers for three or four weeks (in some cases longer) and participate in follow-up outpatient treatment; others attend outpatient treatment sessions over a period of several months. Like diabetes, however, long-term management of chemical dependency requires self-discipline, stable mental health, a social support system, a healthy lifestyle, and access to continuing help to monitor the disease and intervene immediately if there is a relapse.

## The Division of Alcohol and Substance Abuse (DASA)

In 1975, Washington has developed a system for the accreditation of both public and private drug and alcohol treatment programs, and for the financing of treatment for severely addicted and low-income people.

There are about 575 organizations certified by the state as treatment providers. Of these, about 35-40 percent receive public funding; the rest serve only private pay patients. Some of the treatment providers with public contracts serve both state-paid and private pay clients; others serve only clients whose treatment is paid for by the state or by Medicaid.

DASA's work in developing accreditation criteria and consumer protection for clients in treatment has become a national model. While the Department of Health monitors and licenses facilities for basic safety and cleanliness, DASA is responsible for overseeing the quality of the treatment they provide, and ensuring that all treatment and prevention program providers incorporate best practices and recent research findings in their treatment programs.

To provide treatment for the poor, DASA contracts with 27 inpatient treatment centers for residential treatment. Some residential treatment is also provided by tribes and by county governments. DASA also contracts with tribes and county governments, and they, in turn, contract with private providers of outpatient treatment.

DASA also plays an important role in the state's drug and alcohol abuse prevention programs, and is a national leader in research about trends in drug and alcohol abuse and effective treatment innovations.

## Who gets treatment

Today, Washington state law requires that group health insurance policies cover at least some of the cost of chemical dependency treatment. These policies must provide a minimum of $10,680 in treatment benefits for each two-year period, with a maximum out-of-pocket cost to the consumer of $600. The state's Basic Health Plan, which offers subsidized health insurance to low-income people, provides $5,000 for treatment, with somewhat lower patient copayments.

Government-funded treatment is provided only to those who are poor enough to qualify for Medicaid (unemployed parents and their children, and people with disabilities) and to those who are unemployable as a result of their addiction. People who abuse drugs or alcohol, but are not yet addicted, do not qualify for government-paid treatment. Nor do those who may be addicted, but have not (yet) lost their jobs. Thus, there is a sizable layer of low-wage working people who lack private health insurance but are not poor enough to qualify for government help.

There is not enough funding to provide treatment even to those who are eligible and addicted. In fact, DASA provides treatment only to about one in five eligible people who need it.

State and federal governments have set priorities for who receives publicly funded treatment:

- Pregnant women
- Parents raising children
- Parents who are participating in WorkFirst
- Parents referred by Child Protective Services
- Youth, and
- Intravenous drug users.

The lowest priority for treatment is adults who are not raising children.

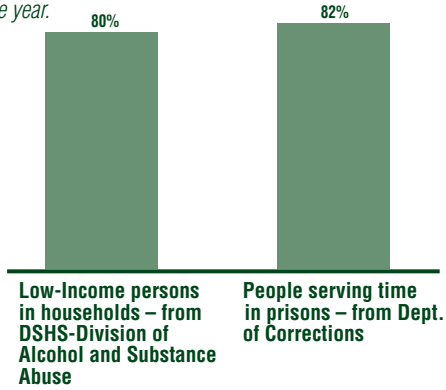
The state's priorities are based on a difficult but essential moral calculation: Children of addicts are in imminent risk of harm when their parents abuse alcohol and drugs, and these children are also at risk for becoming addicts themselves. Therefore, treating pregnant women and parents is essential to reducing the risk of harm to the next generation.

No one would argue with the state's priority on protecting children from the ravages of addiction. But the result is that when single adults come to grips with their addiction and apply for treatment, they are put on a waiting list. That waiting period is filled with both personal tragedy and public expense. Desperately addicted adults commit crimes, harm themselves and others, spread diseases such as HIV/AIDS and hepatitis, and fill our jails and prisons.

Moreover, many of the men who are in the lowest priority group are noncustodial fathers - fathers whose children need them to be alcohol- and drug-free, and able to work, pay child support, and participate in their lives.

### Four out of five people don't get treatment

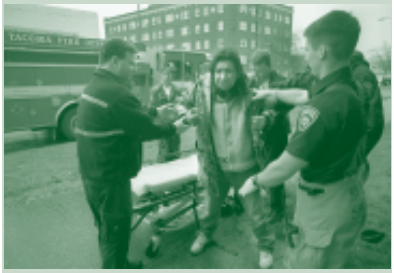
*The overwhelming majority of people who most need chemical dependency treatment do not get it when they need it. The chart below reflects percentage of low-income or incarcerated people who do not receive treatment within one year.*




## Chemical dependency and the criminal justice system

Over the past 20 years, sentences for drug offenses were increased, and the state's prison population burgeoned. But even with longer sentences, sooner or later these offenders will be released back into our communities. Moreover, drug and alcohol abuse is endemic in prison populations, even among those who were convicted of crimes unrelated to illicit drugs. About 25 percent of people in state prisons are there because of drug offenses, but an estimated 70 percent of prisoners have drug or alcohol problems. It is in both their interest and ours that these offenders get the treatment they need before they are released, and the follow-up care they need to stay clean and sober when they are back in our neighborhoods.

### The high cost of alcoholism



Cecil Leading Horse's alcoholism disease has cost taxpayers, hospitals and ambulance services an estimated $2.1 million during his 11 years on the city's streets, according to *The News Tribune* of Tacoma. One private ambulance company ranked him as its top customer in Western Washington and number nine in the nation. His life is dedicated to drinking eight to nine pints of Wild Irish Rose, a fortified wine that costs $2.19 per pint, per day, the paper reported. His story is an extreme case of what can happen when a person dependent upon alcohol and drugs ignores treatment and rehabilitation options, such as the DSHS-funded Pioneer Center North, a long-term residential treatment facility. Such centers have been able to reduce significantly the use of alcohol and other drugs and enhance public health and safety.

Read about his life in *The News Tribune's* feature, " A $2 million binge: the sad, sweet life of Cecil Leading Horse" at Facing the Future Profiles, located at http://www.wa.gov/dshs/FacingtheFuture/NewsProfiles

In the state prison system, 18 percent of those who need treatment are served. The balance go without treatment because the Department of Corrections lacks the resources to provide it.

Yet there is growing evidence that treatment works just as well for those who are compelled to participate as for those who choose to enroll in it. Whether the motivation to remain clean and sober emerges before treatment or during the process of treatment does not seem to affect the overall success rate.

In the last few years, some counties have established "drug courts" in which certain chemically dependent offenders are offered treatment as an alternative to jail or prison time. These offenders are required to attend treatment sessions - usually as outpatients - and to submit to urinalysis to verify that they remain drug- and alcohol-free. A King County drug court evaluation found that only nine percent of drug court graduates were re-arrested for a felony crime after completing the program, compared to 33 percent of those who did not participate. And success rates in these programs support the contention that treatment works even when people are coerced into participating in it.

Drug courts save public dollars because treatment is less expensive than jail time. But funding for drug courts is vulnerable, because they were initially funded by federal grants. Those grants have ended, leaving financial responsibility in the hands of state and local governments.

In 2002, the State Legislature passed the Drug Offender Sentencing Reform Act, which addresses these issues by reducing sentences for certain drug offenses and using the savings in prison costs to fund more treatment. By the year 2005, this is expected to move over $8 million from our budget for prisons to our budget for treatment. Careful studies of this new strategy will track its results.

## Creating effective treatment programs for different kinds of people

The central ideas of treatment are education, reflection, and lifestyle change -

- education about the nature of the disease and its effects,
- reflection on its impact on one's own life, and
- planning how to create and sustain a drug-free lifestyle.

Out of these three elements, patients map out their own, individual paths to sustaining sobriety and creating a healthy life. But different people learn in different ways, at different rates.

### People with developmental disabilities

People with developmental disabilities learn more slowly, and find it very difficult to grasp abstract concepts, or to apply a lesson learned in one area to another area of their lives. Workbooks and reading assignments are often beyond their grasp. Our state

does not have any treatment programs that are specifically designed for the developmentally disabled, but there are treatment programs that are slower paced, and that rely more on visual aids and activities.

## Cultural and language groups

Because treatment is an essentially intimate experience in which people are expected to reveal themselves to others, culture and language also play important roles. A treatment milieu that is culturally comfortable - and a language the patient understands - are essential to success. To serve this need, DASA contracts with treatment centers operated by tribal governments, and with clinics that offer treatment in Spanish and American sign language. DASA also funds specialized programs that serve Asians/Pacific Islanders. (Numerous culturally specific prevention programs are also funded throughout the state.)

## Women

There are also important gender differences that can affect treatment. The majority of women who suffer from chemical dependencies have life issues of sexual/physical abuse, and domestic violence. Those who have longstanding drug dependencies may have worked as prostitutes and experienced periods of homelessness. For these women, remaining clean and sober requires a total change in lifestyle, and in their conception of who they are and what they are worth. To serve these needs, DASA contracts with a number of providers who offer women-only treatment settings.

Most women, however, are enrolled in co-ed treatment.

## Pregnant and parenting women

Pregnant and parenting women also have special needs. Some of these young mothers and mothers-to-be are the children of addicts; nearly all of them grew up in poverty. Some are cognitively impaired, either as the result of a developmental disability or because of fetal alcohol syndrome or other organic damage from their parents' drug use. They often lack virtually all of the life skills they need to sustain sobriety and raise children. Many are functionally illiterate. Some are very young teenagers.

To serve these women, the state contracts with specialized treatment centers that combine chemical dependency treatment with parenting classes, therapeutic child care, mental health services, and intensive case management services to connect women with education, vocational training, and other services. Mothers and their babies (and children, usually up to age six) live together in the residential treatment center for up to six months.

## People with chronic and severe mental illnesses

For the past ten years or more, there has been increasing pressure for the fields of chemical dependency and mental health to do a better job of serving people who are both addicted and severely mentally ill. This is a difficult challenge for several reasons.

Many of the people with both addiction and a mental illness cycle through homelessness, jail, emergency rooms, and state mental hospitals. Even in the best of circumstances, these are people who are hard to keep healthy. When they feel well, they are tempted to stop taking their psychiatric medications. When they are experiencing acute mental illness, they are inclined to self-medicate with alcohol or street drugs. Sustaining sobriety and keeping psychiatric medication balanced and stable is very hard work both for clients and for caregivers. To succeed at this, clients also must have a place to live, faith in their ability to create a better future for themselves, and the practical skills they need to do so.

All this is made even more difficult by the fact that the people who provide drug and alcohol treatment and the people who treat mental illness come from two different worlds. Mental health professionals come from the culture of medicine - the culture of suits and ties and graduate degrees. Chemical dependency professionals come from the gritty tradition of recovery - a tradition of self-help, mutual support, and the expertise that comes from life experience. Many chemical dependency counselors are recovering addicts,

and most of the rest have lived with a family member who was chemically dependent. These two disciplines represent radically different approaches to helping people, and each incorporates science and personal insight in different ways.

Until relatively recently, a psychiatrist might say that there was no point treating an addiction if the patient had unresolved psychiatric issues, and therefore the psychiatric treatment should be treated first. A chemical dependency professional might say that there was no point offering psychiatry to a chemically dependent person, because they would not be able to respond to it until they had cleared up their chemical dependency.

Today, the two cultures are changing in important ways that promise greater convergence and cooperation. Over the years, the field of chemical dependency has raised standards of training and education, and produced more research on treatment innovations and outcomes. Universities have created academic disciplines that lead to advanced degrees in this field.

At the same time, the mental health profession has become more consumer-oriented, and it, too has become more focused on measuring what really works. Some mental health professionals have come to embrace the concept of "recovery" - a concept that empowers people to be self-directed clients rather than passive patients. The idea of recovery is that the person is in charge of the disease rather than the disease being in charge of the person, and that people can learn the skills they need to keep the disease from controlling their lives.

Most chemical dependency treatment providers are unequipped and unwilling to take patients who are acutely mentally ill. To do this, a treatment center would have to have, at the very least, a psychiatrist on hand who could prescribe and manage psychiatric medication. Since the state pays chemical dependency treatment providers $68 a day for inpatient treatment, this is financially impossible except in centers that accept mostly private pay patients, for whom the typical daily rate is about $300.

In spite of these obstacles, DASA and the Mental Health Division of DSHS are moving ahead with collaborative projects that bring more mental health services into chemical dependency treatment settings, and more chemical dependency treatment services into settings that serve mentally ill youth and adults. More professionals in both fields are being cross-trained. Specialized facilities for people with both mental illness and chemical dependency are being created.

Still, these new collaborative efforts are constrained by state policy that limits public chemical dependency and mental health services to those whose illnesses are acute. Chemical dependency treatment is available only to those who are addicted; not to those who abuse drugs or alcohol. Mental health treatment is provided only for people who are seriously mentally ill, not for those who have "mental health problems" such as mild or moderate depression. For many in the early stages of a progressive disease, this policy closes the door on early intervention that might save both money and grief, and do a better job of protecting public safety and health.

## People with physical disabilities

People with disabilities may have trouble accessing treatment for a variety of reasons. They may need personal assistants to help them with tasks of daily living, or may be unable to see well enough to read workbooks or watch treatment videos. People with traumatic brain injuries may also have trouble processing and retaining information.

DASA provides interpreters to people who are deaf or hard of hearing so that they can participate in chemical dependency treatment programs. Washington state also contracts with a special treatment center in Vancouver that serves only those who are deaf or hard of hearing. This is the only such treatment center in the Pacific Northwest, and it is also used by people from Oregon and other nearby states.

## The elderly

Retirement can be a dangerous time for people who are vulnerable to chemical dependency. More time for leisure activities, boredom, and

sometimes depression can be catalysts for the flowering of an addiction. The coming retirement of the baby boom generation will likely place a bigger burden on both DASA and the private providers of substance abuse treatment.

### Youth

Separate youth treatment programs serve adolescents who are referred by parents, foster parents, juvenile courts, school counselors, and themselves. DASA also sends treatment professionals to group homes to provide treatment and train staff. And DASA certifies treatment facilities located in the state's Juvenile Rehabilitation Administration facilities.

### Preventing abuse and addiction

Prevention is a relatively new discipline and has been the subject of rigorous research and quality measurement only since about 1980.

Many agencies, organizations, and schools have been working to prevent drug and alcohol abuse for much longer - and they have been surprised to find that some popular programs used in schools - especially those that relied on scare tactics - were ineffective.

The new approach to prevention is based on an analysis of "risk and protective factors" - the conditions in young people's lives that either raise the risk of drug or alcohol abuse, or that help protect young people from it. This has caused people to think more broadly about reducing risks, increasing the power of protective factors, and targeting prevention efforts to young people who are most vulnerable. The essential features of effective prevention programs are that they are developmentally appropriate - that is, they are targeted to specific age groups; they are culturally relevant; and they address the specific risk and protective factors of a given community or family.

One of the most important findings of recent research about prevention is that there is enormous value in delaying the age at which young people first experiment with drugs and/or alcohol. The younger people are at the time of first use, the more likely they are to become addicted.

DASA is working with several other state agencies, the office of the Lieutenant Governor, and the public school system to create a network of prevention programs that are "science-based" - that is, programs that have been shown by careful research to really make a difference.

Most of this work is funded by a grant from the federal government. These funds are distributed to local community organizations and schools around the state. In most instances, this new generation of prevention programs involve not just educating young people about the dangers of drug and alcohol use, but also creating new opportunities for activities that build a sense of community and family cohesiveness, and provide rewards for positive behavior.

## Treatment as a preventive of illness, medical costs, and social dysfunction

Prevention usually means persuading young people not to use drugs or alcohol. But there is another level of prevention: preventing public expense and further harm to families and communities from continued drug and alcohol abuse.

The power of this level of prevention was clearly demonstrated by the Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project, which was completed at the end of 2001.

This study examined medical costs for people who receive SSI - people with physical or cognitive disabilities or mental illness so severe that they are unable to work. The project measured differences in medical costs for SSI recipients who received chemical dependency treatment and those who appeared to need such treatment but did not get it.

The study found that average monthly medical costs - including estimated costs of chemical dependency treatment - were $540 per month lower for people who got treatment. In one year, this saving totaled $6,480 per person.

Savings were even higher for those 45 and older ($931 per month), for those who were not arrested for drug- or alcohol-related offenses ($739), and for those who were eligible for Medicaid but not Medicare ($704).

# Challenges for the Division of Alcohol and Substance Abuse

## Overcoming the stigma of chemical dependency

There is a reason that Alcoholics Anonymous is anonymous: the stigma of chemical dependency is still so strong that those who suffer from it must cope with life-long embarrassment, blame, and rejection. In spite of all we now know about the biological nature of this disease, our society persists in disapproving of those who have it, and denying its prevalence and impact. This powerful stigma keeps people from acknowledging their illness and seeking treatment. It keeps some people from entering the profession of chemical dependency treatment and prevention, and results in lower pay for those who do.

Perhaps most perplexing, the stigma attached to chemical dependency results in funding treatment for this disease differently than we do any other.

## Increasing capacity

DASA now serves one in five of those who need and qualify for publicly paid treatment.

In our society it would be unconscionable to provide medical care to only one out of five diabetics, or one out of five heart patients. However, chemical dependency treatment has the legacy of stigma - that addiction is a moral failing rather than a disease.

Most people now believe that the addiction is a disease. We also know that treatment works and it could work even better if it were more available, and, in some cases, of longer duration. Funding constraints do not allow this.

## Improving treatment quality

For the past several years, DASA has worked with treatment providers to make treatment more customized and focused on the individual. At one level, this need can be addressed by creating treatment programs that focus on specific groups of people, such as pregnant and parenting women, people with disabilities, and cultural and linguistic groups.

But at another level, focusing on the needs of individuals requires more one-on-one time between counselors and treatment participants. Many people come to treatment with conditions which may not rise to the level of organic mental illness, but which nonetheless interfere with their ability to sustain sobriety. For instance, many young women - and some young men - have been severely traumatized by sexual or physical abuse, and they need help to recover from those experiences and to cope with their after effects. These needs are often neglected in chemical dependency treatment because they require special expertise and extra staffing.

Even in intensive inpatient treatment, the minimum standard of care involves only one hour per week of one-on-one time between treatment participants and their counselors.

This is largely a result of the cost structure of the publicly funded system, which pays inpatient treatment providers only $68 per day per person. Treatment providers must pay for a facility, utilities, meals, laundry, cooks, custodians, bookkeepers, and other support staff - plus treatment professionals - out of this amount.

These rates are the legacy of the grassroots, self-help origins of the treatment profession. They do not reflect the more recent history of professionalization of the treatment field, the rising level of staff education and training, or the real costs of care.

The result is that many treatment providers struggle to stay in business. Those who serve all or mostly public clients are often housed in marginal facilities that barely meet the requirements of the Department of Health. Those who serve primarily private pay

clients, and charge them $300 a day or more, have little incentive to continue to take even a limited number of public clients, and do so only because of a commitment to public service.

**A hard-won victory over addiction**

Bonnie Bohannan, a single Port Angeles mother, has been fighting addiction to methamphetamine and heroin for seven years. She also has been fighting to be a good mother and keep her two daughters with her. Mariann Whalen, a Department of Social and Health Services social worker, has stayed nearby all the time, providing advice, support, intervention – and a heavy dose of hard love. Now Bohannan seems to have triumphed over her addiction.

Read Bonnie Bohannan's story on Facing the Future Profiles, located at http://www.wa.gov/dshs/FacingtheFuture/NewsProfiles

## Training, recruiting and retaining staff

Low state reimbursement rates also mean low salaries for chemical dependency counselors, and this in turn leads to shortages of trained staff and high staff turnover. The median salary of chemical dependency counselors is $29,848. This is lower than the salaries of their counterparts in Oregon or Idaho - and lower than the salaries of mental health professionals.

There is also a shortage of treatment center administrators and supervisors.

DASA is working with the community college system and with the Workforce Training and Education Coordinating Board to help recruit people to this field, and to provide training to people already in the profession. DASA also supports a tuition waiver program for low-income people who want to become chemical dependency counselors. But these efforts may not be enough to fill the growing gap between demand and supply, or the gap between rising educational requirements and stagnating salaries.

## Integrating services

Many people who receive other services from DSHS and its partners are addicted to drugs and alcohol - people with disabilities, people with mental illnesses, people with children, adolescents, and people who are participating in WorkFirst. This means that DASA and its network of contracted treatment providers must coordinate their services with a wide array of other DSHS programs, ranging from Child Protective Services to the Aging and Adult Services Administration. Several recent changes have made this an even higher priority.

WorkFirst emphasizes getting people off welfare and into the work force, and helping to remove the barriers that keep them from doing so. Substance abuse is a common barrier. To identify those who need treatment and to facilitate their getting it, chemical dependency counselors have been stationed at Community Services Offices. This has helped strengthen the relationship between the WorkFirst program and local treatment providers.

There is also a renewed sense of urgency about the care of people who are both mentally ill and chemically dependent. The amount of time people spend in costly state hospitals, jails, and emergency rooms could be reduced if resources could be shifted from these more expensive systems to community-based, integrated chemical dependency and mental health services. More important, clients could lead better lives, and communities would be safer. To succeed at this, there is a need for more facilities that can provide simultaneous mental health and chemical dependency treatment. There is also a need for continuing dialogue and trust-building between mental health and chemical dependency professionals.